

**CALIFORNIA CABG OUTCOMES REPORTING PROGRAM  
CLINICAL ADVISORY PANEL  
TELECONFERENCE MEETING**

**JANUARY 8, 2003  
9:00 a.m. to 12:00 p.m.**

**MEETING MINUTES**

**In Attendance**

*Clinical Advisory Panel Members:*

Andrew Bindman, M.D.  
Ralph Brindis, M.D.  
Cheryl Damberg, Ph.D.  
Coyness Ennix, Jr., M.D.  
Keith Flachsbarth, M.D.  
Fredrick Grover, M.D.  
James MacMillan, M.D.

*From OSHPD:*

David Carlisle, M.D.  
Loel Solomon, Ph.D.  
Joseph Parker, Ph.D.  
Denise King  
Pramela Reddi  
Brooke Rubio  
Herb Jew

*Panel Members Absent:*

Robert Brook, M.D., Sc.D.  
Timothy Denton, M.D.

*CCORP Consulting Cardiologist:*

Anthony Steimle, M.D.

*Other Attendees:*

Dan Patten, Charles Frank and Associates  
Corey Havener, Doctors Medical Center – Modesto  
Noel Concepcion, Valley Heart Surgeons

**Introduction**

This meeting was conducted via conference call. Each call took place at a public meeting site and members of the public were invited to attend.

The meeting began with nominations for an Interim Chair due to the absence of the current chair, Robert Brook, M.D. Cheryl Damberg, Ph.D. volunteered to act as Interim Chair and was approved by all present members of the panel. Dr. Loel Solomon took the official roll call at 9:12 am and the meeting was called to order at 9:16 am.

Minutes from the May 7<sup>th</sup>, 2002 CAP meeting were approved by the majority of panel members in attendance.

**Further Interpretation of the Open Meeting Act**

CAP members' concerns regarding confidentiality and personal liability in light of the Bagley-Keene Open Meeting Act were discussed. According to OSHPD legal counsel,

the Open Meeting Act does not allow a body of the State to go into executive session to consider confidential information including, but not limited to, medical record information. The preferred approach is to expunge identifying information when a body is considering it. CAP members emphasized the need to mask potentially identifying elements, such as volume, when discussing hospitals and surgeons. OSHPD will develop a process for masking these elements.

Regarding personal liability, OSHPD legal counsel has informed staff that CAP members will be covered by government, or limited immunity, for actions that are undertaken in the good faith execution of their duties except for malicious or criminal acts.

### **CCORP Update**

Dr. Parker provided an update on the California CABG Outcomes Reporting Program (CCORP). Following a suggestion from CAP members, CCORP developed and implemented an outreach plan. In July 2002, letters were sent to all Chiefs of Cardiac Surgery. Once all Chiefs of Cardiac Surgery and hospital data contacts were confirmed, follow-up information was sent to the hospitals. Two training sessions were held in November 2002. One training session was taped and a training video was created. Training materials, including a training handbook, are available on the OSHPD website.

CAP members expressed some concern regarding the ability of hospitals to use in-house reporting tools. According to OSHPD staff, hospitals that choose to use an in-house system must submit to rigorous testing before OSHPD will even consider their data for submission. In CCMRP, there were no major problems with hospitals using in-house tools to collect data.

The Society of Thoracic Surgeons (STS) is meeting this week to review their data elements and definitions. CCORP will do its best to make changes in-line with STS allowing for consistency across programs and reducing the burden of data collection on hospitals.

### **CCMRP Update**

Dr. Parker provided an update on the California CABG Mortality Reporting Program (CCMRP). A report based on 1999 data is close to being finished. All hospitals were notified of their final results. The final draft is currently being edited and should be ready for review by the end of January 2003. A CAP meeting will need to be scheduled to discuss the upcoming report based on 2000-2001 data. Currently OSHPD does not have sufficient resources to handle both the voluntary and mandatory programs. Priority has been given to the mandatory program resulting in CCMRP falling behind schedule.

## Record of CCORP Decisions

### 1. Changes to the definition of Isolated CABG:

Motion approved to not list Transmyocardial Laser Revascularization (TMR) as an excluded procedure in the definition of isolated CABG; the CAP would like to revisit this decision in the future when more data is available.

Motion approved to not list Ventricular Assist Devices (VADs) as an excluded procedure in the definition of isolated CABG; the CAP would like to revisit this decision in the future when more data is available.

Motion approved to modify the listed procedure *Repair of atrial and ventricular septa* in Section A to clarify that it should *exclude closure of patent foramen ovale*.

Motion approved to modify the listed procedure *Resection of a portion of the lung* by deleting *wedge resection of a portion of the lung* and by changing *lobectomy with segmental resection of lung* to *lobectomy or segmental resection of lung*.

Motion approved to delete the listed procedure *incisional (ventral) hernia repair* from Section A.

Motion approved to modify the listed procedure *Lumpectomy or mastectomy for breast cancer (not simple breast biopsy)* in Section A by removing *lumpectomy*.

Motion approved to remove *Total or partial excision of thymus (does not include biopsy of thymus)* from Section A.

The cumulative changes to the definition of isolated CABG are as follows:

**Field Name:** *Isolated CABG*

**Definition:** *When any of the procedures listed in section A is performed concurrently with the coronary artery bypass surgery, the case will be considered non-isolated and the data element coded 'No'. It is not possible to list all procedures because cases can be complex and clinical definitions are not always precise. When in doubt, the data abstractor should first seek an opinion from the responsible surgeon and then consult CCORP.*

**Section A**

- *Valve repairs or replacements*
- *Operations on structures adjacent to heart valves (papillary muscle, chordae tendineae, traebeculae carneaee cordis, annuloplasty, infundibulectomy)*
- *Ventriculectomy*
- *Repair of atrial and ventricular septa, **excluding closure of patent foramen ovale***
- *Excision of aneurysm of heart*
- *Head and neck, intracranial endarterectomy*

- *Other open heart surgeries, such as aortic arch repair, pulmonary endarterectomy*
- *Endarterectomy of aorta*
- *Thoracic endarterectomy (endarterectomy on an artery outside the heart)*
- *Heart transplantation*
- *Repair of certain congenital cardiac anomalies (e.g., tetralogy of fallot, atrial septal defect (ASD), ventricular septal defect (VSD), valvular abnormality)*
- *Implantation of cardiomyostimulation system (Note: Refers to cardiomyoplasty systems only, not other heart-assist systems such as pacemakers or internal cardiac defibrillators (ICDs))*
- *Any aortic aneurysm repair (abdominal or thoracic)*
- *Aorta-subclavian-carotid bypass*
- *Aorta-renal bypass*
- *Aorta-iliac-femoral bypass*
- *Caval-pulmonary artery anastomosis*
- *Extracranial-intracranial (EC-IC) vascular bypass*
- *Coronary artery fistula*
- *Maze procedures, surgical or catheter*
- *Resection of a portion of the lung (e.g., excision of an emphysematous bleb, lobectomy or segmental resection of lung). Does not include simple biopsy of lung nodule in which surrounding lung is not resected or biopsy of a thoracic lymph node.*
- *Mastectomy for breast cancer (not simple breast biopsy)*

*If a procedure listed in section B is performed concurrently with the coronary artery bypass surgery, the case will be considered an isolated CABG and the data element coded 'Yes', unless a procedure listed in section A is performed during the same surgery. These particular procedures are listed because the Office has received frequent questions regarding their coding.*

#### Section B

- *Transmyocardial laser revascularization (TMR)*
- *Pericardiectomy and excision of lesions of heart*
- *Repair/restoration of the heart or pericardium*
- *Coronary endarterectomy*
- *Pacemakers*
- *Internal cardiac defibrillators (ICDs)*
- *Fem-fem cardiopulmonary bypass (a form of cardiopulmonary bypass that should not be confused with aortofemoral bypass surgery listed in Section A)*

## 2. Proposed Modifications to Other CCORP Data Elements

PTCA/Atherectomy and PTCA/Atherectomy Interval: Motion approved to modify data element to include all percutaneous interventions, including stents, and to retain the interval timing  $\leq 6$  hours or  $> 6$  hours. The revised data element, to be called Percutaneous Intervention, (PCI) follows:

**Field Name:** Prior PCI

**Definition:** Percutaneous coronary intervention (PCI) was done at any time prior to this surgical procedure (which may include during the current admission). PCI includes percutaneous transluminal coronary angioplasty (PTCA), intracoronary fibrinolysis without PTCA, laser recanalization, stent implantation, rheolysis with angiojet, brachytherapy, and other catheter-based percutaneous recanalization techniques.

**Field Name:** PCI Interval (Interval from PCI to Surgery)

**Definition:** The time between prior percutaneous coronary intervention (PCI) and surgical repair of coronary occlusion:

- ≤ 6 hours
- > 6 hours

Angina: Motion approved to revise the definition of angina to eliminate the 24 hour time window in the current STS and CCORP definitions. The modified data element for Angina is:

**Field Name:** Angina

**Definition:** The patient has ever had angina pectoris.

Angina Type: Motion approved to revise the definition of Angina Type as follows:

**Field Name:** Angina Type

**Definition:** The type of angina present prior to the CABG surgery is:

*Stable:* Does not meet unstable criteria below.

*Unstable:* Requires continuous hospitalization from the episode until surgery and one of the following:

1. Angina at rest.
2. New onset angina within the past 2 months of at least Canadian Cardiovascular Society (CCS) Class III.
3. Recent increase within the past 2 months of one class to at least CCS Class III.
4. MI by enzymes.

Motion passed to allow Dr. Grover, Dr. Brindis, and Dr. Steimle to do some minor “wordsmithing” to the definition of angina and angina type to ensure consistency with the new STS and ACC definitions.

Myocardial Infarction (MI): Motion approved to modify the definition of MI to distinguish between remote MIs that occurred prior to the current hospitalization for CABG surgery and MIs that occur during the same hospitalization. For remote MIs, clinician documentation in the medical chart is sufficient. For acute MIs, clinician documentation and additional criteria provided by the European Society of Cardiology and the American College of Cardiology, published in the September 2002 Journal of the American College of Cardiology (JACC) is required.

Hepatic Failure: Motion approved to add acute hepatitis and “shock liver” to the definition of hepatic failure.

***Field Name:*** *Hepatic Failure*

***Definition:*** *The patient has cirrhosis, hepatic failure, acute hepatitis or “shock liver” and has a bilirubin greater than 2mg/dl and a serum albumin less than 3.5 grams/dl.*

Cardioplegia: Motion approved to not modify this data element.

Race/Ethnicity: Motion approved to not modify this data element. CCORP data can be linked to patient discharge data (PDD) if ethnicity is required for analysis.

Payor: Motion approved to delete primary payor as a required data element.

### 3. Additional Outcome Measures

Motion approved to add no further outcome measures at this time, including the complications recommended to the Office by commentators. Staff was directed to further assess the coding reliability, prevalence rates and competing definitions for complications to be reviewed in the future.